Summary of Testimony to the Energy and Commerce Committee on HR1328
James Allen Crouch M.P.H.

I am Executive Director of the California Rural Indian Health Board, Inc. (CRIHB) I served as Tribal Co Chair of the Title IV Workgroup for the Reauthorization of the IHCIA. I am a founding member of the Tribal-Technical Advisory Group to the Centers for Medicare and Medicaid Services (CMS T-TAG), a graduate of the UC Berkeley School of Public Health and a member of the Cherokee Nation. CRIHB is a founding member of the National Indian Health Board (NIHB) and under Indian Self Determination Act contracts provides health and health related services to 22 tribes in California. One of the most important changes in the first generation of the IHCIA was the authorization for IHS facilities to bill Medicare and Medicaid for services provided to Indians. This joint funding process created many changes and makes IHS funds the payer of last resort secondary to Medicaid or Medicare coverage. Since that time the health needs of the Indian community have shifted as have standard methods of providing care. The movement has been away from acute conditions to chronic and away from facilities to community base programs. These changes have required a thoughtful response from Tribes, the IHS and now Congress as you consider the reauthorization of the Indian Health Care Improvement Act. CRIHB fully endorses HR 1328 and urges its quick passage.

The new Title II addressing programs under the Social Security Act is the most important part of HR 1328. It responds to current needs such as the increasing role of technology and equipment in maintaining health and quality of life by clarifying that the ITU system may seek reimbursement for furnished items such as wheel chairs, home diabetic equipment and diabetic test strips etc. It is designed to address persistent problems of under enrollment in CMS funded programs by eligible American Indians and Alaska Natives through state-tribal collaborations. It addresses new barriers to access that result from many American Indians having been born at home with out birth certificates or in federal facilities that did not collaborate with their state vital record departments. The most significant changes are in section 204 which has the general effect of waving all premiums and co payments for IHS eligible Indians who receive Medicaid, Medicare or S-CHIP funded services at or through referral by an ITU provider. The extension of this exception to services provided under referral is particularly important in IHS service Areas such as California, Nashville, Bemidji and Portland where there are no IHS hospital facilities. In these Areas almost all inpatient and specialty care is provided by non IHS providers. It calls for an annual report on Indian participation and health outcomes from the CMS and the IHS. This report will have the beneficial effect of increasing the understanding of both Agencies about the role they respectively play in providing health care to American Indians and Alaska Natives. A responsibility they have shared since the initial passage of the Indian Health Care Improvement Act in 1976.

Title I Section 209 of HR1328 concerning Epidemiology Centers clarifies their status as "public health entities" under HIPPA and that such data sharing will occur with out diminishment of HIPPA accountability. CRIHB strongly supports this provision. CRIHB also supports the Abercrombie amendment addressing this section recently adopted by the House Resources Committee.

CRIHB actively and fully supports HR 1328 and urges its quick passage into law.

Testimony James Allen Crouch M.P.H
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HR 1328, the Indian Health Care Improvement Act Amendments of 2007

I would like to begin by thanking the Committee for this opportunity to present the perspectives of the California Rural Indian Health Board Inc. (CRIHB) on HR 1328 the Indian Health Care Improvement Act Amendments of 2007 and to document our support for this important piece of Indian legislation. CRIHB is a Tribal Organization operating under the authority of the Indian Self Determination Act providing health and health related services to twenty-two tribes and other Indian Health Service (IHS) eligible Indians residing near those reservations. CRIHB was originally organized in 1969 at a time when all IHS services had been removed from the state and our first major accomplishment was the return of those services through Congressional action in 1972. Our founding documents call for CRIHB to be active in health policy at all levels of government. True to that mission, the organization has been actively involved in the initial passage of the IHCIA and in each cycle of reauthorization since that time. Today operating as an association of Tribally Operated Health Programs funded through various federal, state and philanthropic sources, we provide over $31 million in health related programming for the benefit of Tribes, Tribal Health Programs and Urban Indian Organizations in California. Our member Tribally Operated Health Programs serve over 46,200 American Indians and Alaska Natives with IHS-funded comprehensive health care services. As has been the case for the past decade, at our Annual meeting last October with over 200 Tribal and Tribal Health Program leaders in attendance, the reauthorization of the Indian Health Care Improvement Act was identified as our principal legislative goal for the year. We hope that this year marks the year in which that goal is achieved.

You may well ask yourselves why is the reauthorization of this bill, which has languished in Congress for a decade, so important to Indian country in general and in particular to Tribes, Tribal Health Programs and the American Indians and Alaska Natives they serve in California. The answer to that question is found in reviewing the role and purpose of the IHCIA itself and in the vast diversity among tribes across the nation. In 1976 with the initial passage of the IHCIA Congress for the first time provided a clear goal for the Indian Health Service: "the elevation of the health status of the American Indian people." To achieve this central purpose, the Act authorized a broad list of programs and improvements addressing problems of manpower development, staffing, organizational improvements and specific health interventions or programs. One of the most important provisions included in the IHCIA was the authorization many years ago for the IHS to bill for services provided to Medicare and Medicaid covered Indians in IHS facilities. Today CMS funded programs provide at least a third of the IHS operating program in places like California. This new "joint funding" of the IHS services requires that the IHS funds become the payer of last resort for services to Indians this has expanded the level of resources available to fund such care. At the same time this increasing dependence on

CMS funded programs increases the need for CMS to respond to the needs of Tribal communities. Today, more that ever, how Medicaid, S-CHIP and Medicare are implement in Indian county impacts on which Indians receiver which health service and at what price.

The bill is broad and lengthy because the diversity of Indian country requires a diversity of programs to effectively address problems as they exist. The IHS service population is widely dispersed from the polar regions of Alaska to the steamy forests of Florida. Tribes vary greatly in size of membership. Some Tribes are located on large reservations which are remotely located far from normal medical services and others, like many of those in California, have smaller reservations where the accessibility of non-IHS providers is less problematic. Today many members of federally-recognized tribes do not live on their own reservations. At present twenty five percent of the IHS Active User population receiving services from California based Tribally Operated Health Programs are members of federally recognized tribes based outside of the state of California. There are also many American Indians living in urban areas across the country. Reflecting back to 1976 and the initial passage of the IHCIA, there are also now differences in how IHS health services are provided either directly by the agency in consultation with the Tribes they serve or under Tribal control through contracts and compacts as authorized by the Indian Self Determination and Education Assistance Act (ISDA) which was initially passed as PL 93-638 in 1977. Today over half of the IHS system is operated by Tribes and Tribal Organizations through ISDA contracts and compacts. In spite of all this diversity and change there are still many common characteristics among tribes and Indian people. There is the shared heritage of first contact, eventual conflict, marginalization, and perhaps revitalization. IHS data describe a population which has overcome tuberculosis and infant mortality which now struggles with mental health and behavioral health problems, and is confronting the ravages of diabetes, obesity and hypertension with its attendant amputations and heart problems-- a population that is now living longer but still lags behind the majority of the U.S. population in average age of death.

The health needs of the Indian community have changed over time requiring a thoughtful response from the Indian community, the IHS and Congress in the reauthorization of the Indian Health Care Improvement Act (IHCIA). Since the first passage of the IHCIA meaningful progress has been made in addressing the health needs of the American Indian population and thereby improving their health status. It is, however, equally true that patterns of disease, life style and mortality within the Indian community are shifting bringing to the fore new problems that respond best to new modalities of care. HR 1328, the Indian Health Care Improvement Act Amendments of 2007, addresses these changes well and is fully supported by the California Rural Indian Health Board, Inc.

Most of my comments below address the provisions of the new Title II sections of the HR 1328 which I believe will have significant positive impacts on access to care for IHS-eligible American Indians and Alaska Natives. I urge that these provisions be enacted as currently drafted and as swiftly as possible. My recommendations are informed by my personal background as Executive Director of the California Rural Indian Health Board, a position I have held for the past twenty years; as Tribal Co-Chair of the Title V

Workgroup of the National Committee for the Reauthorization of the IHCIA; as a founding member of the Tribal-Technical Advisory Group to the Centers for Medicare and Medicaid Services (CMS T-TAG); as a graduate of the UC Berkeley School of Public Health; and as a member of the Cherokee Nation.

The new Title II Amendments to the Social Security Act up-dates clarifies and expands Indian participation in Medicare, Medicaid and the State-Children Health Insurance Program. This portion of the bill refers back to Title IV of the current IHCIA where the original authority for the IHS to bill Medicare and Medicaid was placed. First I should clarify some common IHS and tribal terminology. The different delivery modalities of the IHS funded system is often described collectively as the ITU system or individually as "I" "T" or "U" providers. "I" refers to the Indian Heath Service operated programs; "T" refers to the Tribally operated programs; and "U" refers to the Urban Indian programs.. Also, I will in general refer to the IHS eligible population as Indians instead of the more fully descriptive American Indians and Alaska Natives.

Section 201 clarifies that the Indian Health Service, Tribes, Tribal Organizations and Urban Indian Organizations are eligible for payment for services which are generally reimbursed by Medicare, Medicaid and S-CHIP. Responding to the increasing role that technology and assistive equipment plays in maintaining health and quality of life this section expands and clarifies that the ITU system may also seek reimbursement for furnished items like wheel chairs, home diabetic test equipment and diabetic test strips etc. To receive payment for these services the ITU provider would have to meet generally applicable standards and conditions. To facilitate entry into these new service areas, Section 201 allows ITU providers to operate for a limited one year time period under a Secretarial-approved plan for meeting general standards and conditions of participation. This is similar to the authority given to the IHS in 1976 when the billing of Medicaid and Medicare for clinical services was first granted directly to IHS facilities. Today to the extent that some ITU providers might want to provide new non-clinical services such as long term care services or home health care services, this provision provides for a reasonable start up period and process.

Section 202 is designed to address the persistent problem of under-enrollment in CMS funded programs by eligible American Indians and Alaska Natives. There are a number of reasons why participation in these programs is low including the lack of clear guidance to states on what they can do to address this situation. The bill addresses this and identifies several methods as being acceptable including the out stationing of state staff and entering into agreements with Tribal and Urban providers to provide outreach education and enrollment services. These efforts are intended to augment access to the Medicaid Administrative Match program which is operating successfully in some parts of Indian country. Lastly Section 203 provides a financial incentive to States to include ITU providers in S-CHIP funded outreach to Indian families and Indian children by exempting those costs from the state caps on such costs. Some states like California have previously entered into contract and grant agreements with Tribal Providers to expand Indian participation in S-CHIP but that practice has decreased over time as funding constraints became more common. Overall the cost of increasing enrollment in CMS-funded

programs would be minor compared to the positive improvement in access for individual Indian people and the increase in revenues that would accrue to the generally under-funded IHS, Tribal and Urban providers.

Not all barriers to Medicaid participation are financial. American Indians have had a particularly difficult time addressing the recent Medicaid requirement to document citizenship as part of the enrollment process. This has created a new barrier to access because many American Indians and Alaska Natives were born at home with no birth certificate being issued or in federal facilities that did not collaborate with their state vital record departments. Current Medicaid practice states that Tribal documents from only five tribes are fully acceptable as proof of US Citizenship. The selection process to identify these Tribal Governments is lost in history except for the recent inclusion of the Isleta Del Sur under authority of the Department of Homeland Security. Section 203 addresses this issue by including documents issued by federally recognized Indian tribes in the list of acceptable proof of US citizenship. For those tribes having an international border which have tribal members that are not US citizens, the Secretary, after consultation with the tribes, is to determine what would constitutes acceptable documentation. It should be noted that two of the current list of five Tribes able to provide acceptable documentation of citizenship are located on international borders.

The most significant changes of Title II Changes to the Social Security Act in HR 1328 are found in section 204 which has the general effect of waving all premiums and co-payments for IHS eligible Indians who receive Medicaid, Medicare or S-CHIP funded services at or through referral by an ITU provider. The American Indian/Alaska Native population is characterized by low rates of educational attainment, high rates of unemployment, disproportionably low health status and high rates of ambulatory care sensitive hospitalizations. In short, in spite of the existence of the IHS delivery system there is evidence of inappropriately low levels of health care utilization resulting from continuing barriers to care. The existing cost barriers to Medicaid funded care are unnecessary and should be removed because they decrease utilization of medically appropriate services. IHS facilities are prohibited from charging individual Indians for services that could be provided through the IHS congressional appropriation and therefore generally absorb these costs. Additionally in the Indian context Tribal responsibility expressed through Indian Self Determination Act contracting closes the circle of responsibility at the Trial level not merely at the individual level Lastly there is scarcely any creditable documentation of Indian over utilization of health services while there are mountains of evidence documenting underutilization and late utilization. In California for example a recent study documented that IHS clients there are receiving too few primary care services and are therefore twice as likely as their non Indian neighbors to be hospitalized for certain primary care sensitive diagnosis. The Congressional Budget Office has calculated the cost of this provision at $5 million in year one, $10 million in year two and $15 million there after. This is a small price to pay for the resulting increase in health services and the subsequent resulting improvements in health access and health outcomes. These special Indian provisions are similar to long standing practice under the S-CHIP program .

The extension of this provision waiving all premiums and co-payments for referral services is particularly important in IHS service Areas such as California, Nashville, Bemidji and Portland where there are no IHS hospital facilities. In these Areas, almost all inpatient and specialty care is provided through referral to non-IHS providers. In the other IHS Areas where IHS operates a vertically integrated preventive, ambulatory and inpatient system, there are no charges levied on individual Indian clients. Section 204 also establishes a prohibition against any attempt to reduce payments for services to IHS eligible Indians provided by the ITU system either directly or through medical referral for the furnishing of both items and services to Medicaid covered individuals. This prohibition is necessary in order to protect IHS and non-IHS providers from possible reductions in payments under state Medicaid plans that would inevitably reduce the number of non-Indian providers willing to provide services to Indians under those conditions. The third critical provision in this section elevates into statute and extends to the S-CHIP program existing Medicaid regulations that provide for a limited exemption of Indian trust based property and income from consideration in determining eligibility for those programs.

Section 205 through Section 208 address the relationship of the ITU system to Medicaid and S-CHIP contracting Managed Care Organizations. In general these provisions replicate rules long established by the State of California which have been successfully in operation for over a decade. These provisions allow for ITU participation while maintaining existing requirements for licensure and applicable standards for participation in such programs.

Section 206 addresses Consultation between Tribes and the Center for Medicaid and Medicare Services elevating into statue the existing Tribal-Technical Advisory Group and authorizing the addition of representation for IHS-funded Urban Indian Organizations. The current T-TAG operates under Federal Advisory Committee Act which does not allow for representation by non-governmental groups not based in the Washington DC area. The T-TAG has been of active assistance to CMS since September 2003 and has assisted in the start up of Medicare Part D program, implementation of Budget Reduction Act provisions, Medicaid Administrative Match program issues and issues surrounding Indian data in CMS data systems. This section further mandates that states with ITU providers establish a regular process for seeking advice in matters that are likely to have a direct effect on those providers including state Medicaid plan amendments and demonstration programs. The state of Washington has a well established program for this type of tribal consultation which has greatly facilitated collaboration between the Tribal Health Programs there and the state.

Section 207 addresses problems that might arise from the vertically integrated nature of the IHS delivery system where portions of the program are operated directly by the IHS and other portions are operated by Tribes and Tribal Organizations under Indian Self Determination Act contracts and compacts or by Urban Organizations under grants and contracts. This section calls for the Secretary to promulgate regulations though which certain transfers shall not be considered remuneration for the purposes of creating a Safe Harbor. These provisions protect the coordination of "medically necessary services"

between and among ITU providers under certain conditions. These provisions are also designed to prevent unnecessary utilization and cost concerns that can arise from self dealing in the commercial health services market.

Section 208 is similar to state regulations in California which address specific problems that arise when individual Indians who have established a medical home with an ITU provider are subsequently enrolled in non-Indian Managed Care Organizations. This situation occurs when states seek to expand their utilization of Managed Care Organizations for the provision of Medicaid and S-CHIP services. The proposed law guarantees the right of the individual Indian client to continue to choose their ITU provider as their primary care provider. For those MCO's that have a significant percentage of Indian enrollees, new requirements are established assuring participation of the ITU providers in their system of care and assuring that non-participating ITU providers are reimbursed in an equitable manner. These provisions are designed to assure the availability of culturally competent care to individual Indian beneficiaries. If the Tribe or Tribal Organization operates as a Federally Qualified Health Center or under the IHS/HCFA memorandum of agreement, the ITU providers are assured continued assess to that rate if they so choose. In cases where there is a difference between the CMS established encounter rate and the MCO rate, that difference shall be made up through direct payment by the state plan to the ITU provider. These provisions are congruent with existing federal law concerning FQHC participation in Managed Care Organizations.

This section goes on to address the special case of state-licensed Indian Managed Care Organizations and their participation as Medicaid or S-CHIP providers. It should be noted that to date all initial attempts to organize Indian controlled and focused Managed Care Organizations have not succeeded. The bill requires that such an entity meet generally applicable standards and conditions. However it also seeks to foster the development of Indian controlled Managed Care entities by establishing special conditions that would greatly facilitate the development of Indian controlled MCO's for participation in state controlled Medicaid Managed Care systems. This first of these special conditions is the authority to limit enrollment and distribute marketing materials selectively to American Indians and Alaska Natives. This is in conformity with the IHS mission and serves as a means of increasing access to culturally competent care for individual Indian beneficiaries. Enrollment provisions are established that both protect the rights of individual Indians to select non ITU providers and allowing for default enrollment of eligible Indians into Indian managed care plans. In those states where patient lock-in provisions have been established, the individual Indian's right to choose an Indian MCO supersedes those provisions. A provision is also made establishing that and Indian MCO would be deemed a public entity for whom standards of solvency would be established by the Secretary, not by an individual state. Issues which have arisen in the past concerning state requirements for MCO's to carry malpractice insurance are addressed by recognizing that the IHS and Tribal providers as well as Urban Programs operating as FQHC's are covered by the Federal Torts Claims Act.

HR 1328 ends with provisions that call for the Secretary acting through the Administrator of CMS and the Director of the Indian Health Service to provide an annual report to Congress regarding the enrollment and health status of Indians receiving items or services funded by CMS under the provisions of this act. As Chairman of the CMS/T-TAG Data Subcommittee I can attest to the need for this report. Calling for such a report will have the beneficial effect of increasing the understanding of both Agencies about the role they respectively play in providing health care to American Indians and Alaska Natives, a responsibility they have shared since the initial passage of the Indian Health Care Improvement Act in 1976. The current CMS data architecture hinders the collection of comprehensive data on Indian participation, service utilization, cost and outcomes. Anomalies in definitions used by CMS and the sources of individual Indian identifiers will eventually need to be addressed before system wide conformity can be achieved. This is not an impossible task but one that will evolve over time. It should be noted that IHS/CMS and the Social Security Administration have for several years been participating in a data sharing agreement that has greatly improved the quality of Medicare related Indian data and SSN identified IHS data. Equal improvement in Medicaid related data will be more difficult but not impossible to achieve. The increased utilization of Electronic Health Records systems by ITU providers will also facilitate the development of this report over time.

Recently the National Tribal Steering Committee for the Reauthorization of the Indian Heath Care Improvement Act requested that the Senate Indian Committee add a new provision to Title II which would clarify that CMS should address services to American Indians and Alaska Natives in conformity with the landmark U.S. Supreme Court decision in the case of *Morton v. Mancari,* 417 U.S. 535 (1974). That decision held that Indians are entitled to special services not as a racial or ethnic group, but instead because of their political status as members of Indian tribes. The Steering Committee is suggesting the following language be inserted into the bill.

> "In recognition of the unique responsibility of the United States to provide health care to Indians, the Secretary shall ensure the maximum participation by Indians and Indian Health Programs in the health benefit programs funded under this Act."

This change would be helpful to CMS as it addresses issues of how to change its data systems to reflect Indian participation and makes other policy decisions on the implementation if their health's benefit programs.

While reflecting on the issues of data, date quality and access, I would like to take this opportunity to address section 209 of Title I of HR1328 concerning Epidemiology Centers. For a number of years Congress has required the establishment of Epidemiology Centers in each of the twelve IHS Areas. HR1328 appropriately continues that goal and clarifies that such centers shall be treated as "public health authorities" for the purposes of access to data under the Health Insurance Portability and Accountability Act (HIPAA). A plain English reading of EpiCenter roles and responsibilities and a plain English

reading of how the "public health authority" of the IHS is delegated by contracts and grants to Tribes and Tribal Organizations has not been sufficient to foster appropriate and timely sharing of data between the IHS and its funded EpiCenters. Title I section 209 clarifies that such data sharing can occur and with no diminishment in HIPPA accountability. CRIHB strongly supports this provision. CRIHB also supports the Abercrombie amendment to this section which was recently adopted by the House Resources Committee which is more clearly drafted than parts of the current language and provides greater continuity with existing law.

In closing, I would like to express the strongest possible support for HR 1328 and urge its speedy passage into law. Over a decade ago a series of open national meetings were held to discuss and analyze how the IHCIA could be updated to reflect current conditions among the Tribes and changes in how health care is provided today. The current bill reflects the historic consensus proposal that was generated through this process and a few more recent, yet fully vetted, incremental changes. Passage of HR 1328 will not only achieve the goals of the Indian community to update the authorities under which Indian health care is delivered, but it is also a small but significant step towards national heath reform. Thank you for this opportunity to share my views and those of the California Rural Indian Health Board.